SECTION 11

Other services

Dialysis
Hospice
Clinical laboratory

Chart 11-1. Number of dialysis facilities is growing and share of for-profit and freestanding dialysis providers is increasing

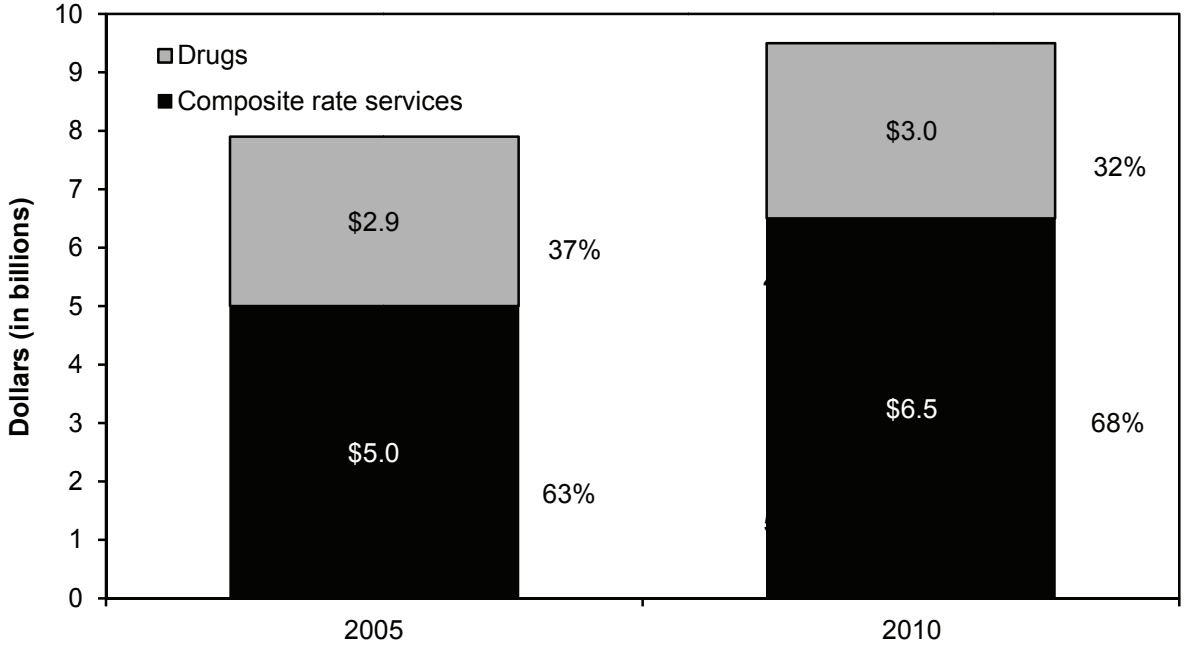
	2011	Average annual percent change 2006–2011	2010–2011
Total number of:			
Dialysis facilities	5,560	4%	3%
Hemodialysis stations	98,603	5	4
Mean number of hemodialysis stations per facility	18	0.3	0.5
Hospital based	10	–2	–3
Freestanding	90	5	3
Urban	78	4	3
Rural, micropolitan	14	3	1
Rural, adjacent to urban	5	4	3
Rural, not adjacent to urban	3	4	2
Frontier	1	1	3
For profit	83	5	4
Nonprofit	17	–1	–3

Note: Nonprofit includes facilities designated as either nonprofit or government.

Source: Compiled by MedPAC from the CMS Dialysis Compare file.

- Between 2006 and 2011, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 86 percent to 90 percent of all facilities, and for-profit facilities increased from 79 percent to 83 percent of all facilities.
- Between 2006 and 2011, the proportion of facilities located in rural areas has remained relatively constant.
- The number of facilities has increased 4 percent per year since 2006. The average size of a facility has increased slightly, as evidenced by the mean number of hemodialysis stations per facility, which increased from 17 in 2006 to 18 in 2011.

Chart 11-2. Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2005 and 2010



Source: Compiled by MedPAC from the 2005 and 2010 institutional outpatient files from CMS.

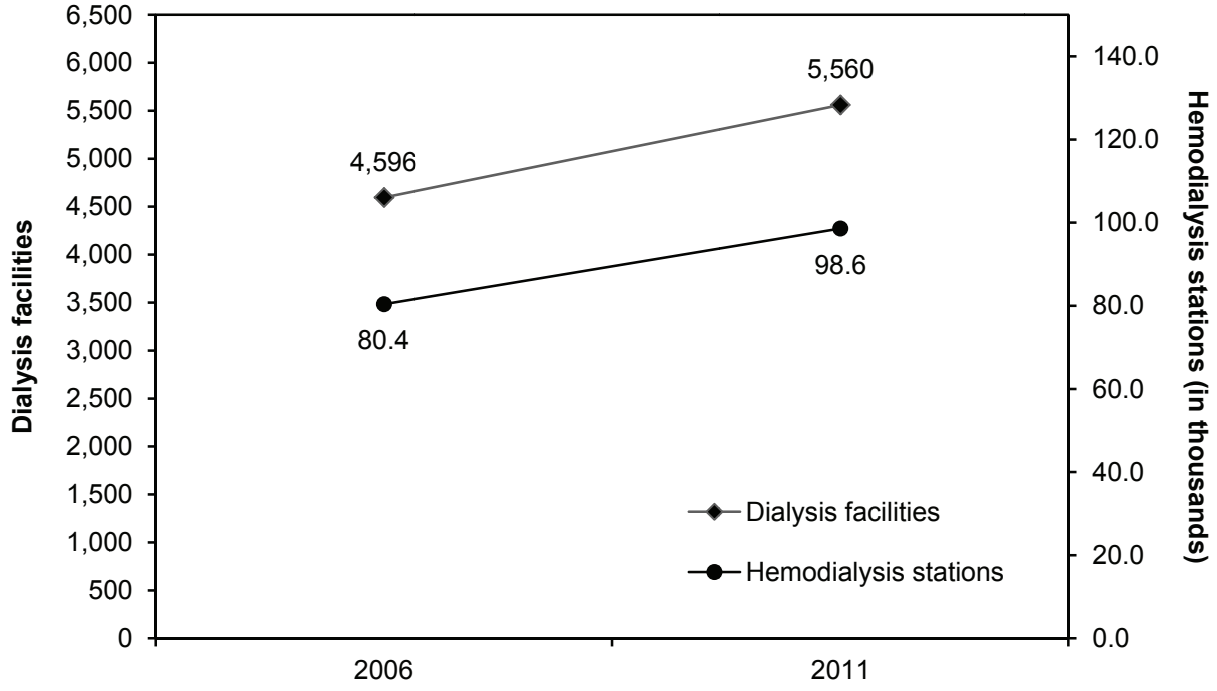
- Between 2005 and 2010, total expenditures for composite rate services and dialysis drugs increased by about 4 percent per year. During this time, expenditures for composite rate services increased by 5 percent per year while expenditures for dialysis drugs increased by 0.5 percent per year.

- Freestanding dialysis facilities treat most dialysis beneficiaries and accounted for 88 percent of expenditures in 2005 and 91 percent of expenditures in 2010. Between 2009 (reported in MedPAC's June 2011 Data Book) and 2010, total Medicare expenditures for dialysis services at freestanding dialysis facilities increased by 4 percent to $8.7 billion.

- The decline in the proportion of spending for dialysis drugs and the increase in the proportion of total dialysis spending for composite rate services is due to statutory and regulatory changes. Beginning in 2005, CMS implemented policies that increased Medicare's payment rate for composite rate services but lowered the rate for dialysis drugs.

- In addition to the change in the drug payment rate, the per capita use of erythropoiesis-stimulating agents, the drug class accounting for three-quarters of dialysis drugs spending, declined between 2009 and 2010. This decline is linked to new clinical evidence about the appropriate use of these drugs. Also, some providers, beginning in 2010, began to phase in new (lower) prescribing protocols for dialysis drugs in anticipation of Medicare's change to a bundled payment method in 2011 that no longer pays separately for these drugs.

Chart 11-3. Dialysis facilities' capacity increased between 2006 and 2011



Source: Compiled by MedPAC from the Dialysis Compare database from CMS.

- Providers have met the demand for furnishing care to an increasing number of dialysis patients by opening new facilities. In 2011, an average facility had about 18 hemodialysis stations.
- Between 2006 and 2011, the total number of dialysis facilities grew by about 4 percent annually, and the number of hemodialysis stations grew by 5 percent annually.

Chart 11-4. Characteristics of Medicare fee-for-service dialysis patients, 2010

	Percent of all FFS dialysis patients
Age (years)	
Under 45	12%
45-64	37
65-74	25
75-84	19
85+	7
Sex	
Male	54
Female	46
Race	
White	51
African American	36
All other	14
Residence	
Urban county	81
Rural county, micropolitan	11
Rural county, adjacent to urban	5
Rural county, not adjacent to urban	3
Frontier county	1
Prescription drug coverage status	
Enrolled in Part D plan	70
Coverage through employers that receive RDS	10
Coverage through other creditable sources	11
No creditable coverage	9
LIS	55*
Medicare as the secondary payer	7*
Dually eligible for Medicaid	47

Note: FFS (fee-for-service). RDS (retiree drug subsidy), LIS (low-income subsidy). Urban counties contain a core area with 50,000 or more population, rural micropolitan counties contain at least one cluster of at least 10,000 and less than 50,000 population, rural counties adjacent to urban areas do not have a city of 10,000 people in the county, and rural counties not adjacent to urban areas do not have a city of 10,000 people. Frontier counties are counties with six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.
*2009 estimates

Source: MedPAC analysis of dialysis claims files and denominator files from CMS.

- Compared with all Medicare patients, FFS dialysis patients are disproportionately younger and African American.
- In 2010, about 20 percent of FFS dialysis patients resided in a rural county.
- Nearly half of all dialysis patients were dually eligible for Medicare and Medicaid services.
- Medicare was the secondary payer (for Part A and Part B) for 7 percent of FFS dialysis patients who were insured by an employer group health plan at the time they are diagnosed with end-stage renal disease.
- About 91 percent of FFS dialysis patients were enrolled in Part D plans or have other sources of creditable drug coverage.

Chart 11-5. The ESRD population is growing, and most ESRD patients undergo dialysis

	1999		2005		2009	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	372.0	100%	487.6	100%	571.4	100%
Dialysis	269.7	73	343.9	71	398.9	70
In-center hemodialysis	240.3	65	314.6	65	365.8	64
Home hemodialysis	2.4	1	2.2	<1	4.5	1
Peritoneal dialysis	25.9	7	26.1	5	27.6	5
Unknown	1.1	<1	0.9	<1	1.0	<1
Functioning graft and kidney transplants	102.4	28	143.7	29	172.6	30

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding. The above data includes both Medicare and non-Medicare patients.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with ESRD require either dialysis or a kidney transplant to maintain life. The total number of ESRD patients increased by 4 percent annually between 1999 and 2009.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is usually performed in a patient's home.
- Most ESRD patients undergo hemodialysis administered in dialysis facilities three times a week. Between 1999 and 2009, the total number of in-center hemodialysis patients increased by 4 percent annually while the number of patients using the predominant home modality—peritoneal dialysis—remained about the same. Although only a small proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew 7 percent annually during this time period.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living or a cadaveric kidney donation. In 2009, 36 percent of the kidneys were from living donors and 64 percent were from cadaver donors.

Chart 11-6. Diabetics, middle-aged and the elderly, Asian Americans, and Hispanics are among the fastest growing segments of the ESRD population

	Percent of total in 2009	Average annual percent change 2004–2009
Total (*n* = 571,414)	100%	4%
Age (years)		
0–19	1	1
20–44	18	1
45–64	45	5
65–79	28	4
80+	9	5
Sex		
Male	57	4
Female	43	4
Race/ethnicity		
White	61	4
African American	32	4
Native American	1	4
Asian American	5	8
Hispanic	15	7
Non-Hispanic	85	4
Underlying cause of ESRD		
Diabetes	38	5
Hypertension	25	4
Glomerulonephritis	15	2
Other causes	23	5

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding. ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among ESRD patients, 37 percent are over age 65. About 61 percent are White.
- Diabetes is the most common cause of renal failure.
- The number of ESRD patients increased by 4 percent annually between 2004 and 2009. Among the fastest growing groups of patients are those who are between 45 and 64, over age 80, Asian Americans, and Hispanics.

Chart 11-7. Aggregate margins vary by type of freestanding dialysis facility, 2010

Type of facility	Percentage of Medicare payments going to freestanding facilities	Aggregate margin
All facilities	100%	2.3%
Urban	85	3.4
Rural	15	–3.7
LDOs	69	3.4
Non-LDOs	31	0.1

Note: LDO (large dialysis organization). Margins include payments and costs for composite rate services and injectable drugs.

Source: Compiled by MedPAC from 2010 cost reports and the 2010 institutional outpatient file from CMS.

- For 2010, the aggregate Medicare margin for composite rate services and injectable drugs was 2.3 percent.
- As in earlier years, we continue to see higher margins for facilities affiliated with the two largest dialysis organizations. This finding stems from differences in the composite rate cost per treatment and drug payment per treatment. Compared with their counterparts, the composite rate cost per treatment was lower and the drug payment per treatment was higher for the two largest chains.
- In 2010, the gap between the Medicare margins for urban and rural facilities widened because of differences in the volume of drugs furnished across providers. In addition, compared to urban facilities, rural facilities are on average smaller, in terms of the number of treatments they provide, and have higher cost per treatment for composite rate services. The Commission will continue to monitor the adequacy of Medicare's payments for urban and rural facilities in upcoming years. Some rural facilities may benefit from the low-volume adjustment that is included in the new end-stage renal disease payment method that began in 2011.

Chart 11-8. Medicare hospice use and spending grew substantially from 2000 to 2010

	2000	2009	2010	Annual change, 2000–2009	Change, 2009–2010
Beneficiaries in hospice	513,000	1,090,000	1,159,000	8.7%*	6.3%
Medicare payments (in billions)	$2.9	$12.1	$13.0	17.2*	7.2
Average length of stay among decedents (in days)	54	84	86	5.0*	2.1
Median length of stay among decedents (in days)	17	17	18	0 days	1 day

Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.
*Average annual change.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims Standard Analytic File from CMS.

- The number of Medicare beneficiaries receiving hospice services more than doubled over the last decade and continued to grow in 2010, suggesting that access to hospice care has increased.
- The average length of stay among Medicare decedents who used hospice grew substantially over the decade, from 54 days in 2000 to 86 days in 2010. This growth reflects an increase in length of stay among hospice users with the longest stays while median length of stay has changed little (see Chart 11-12).
- Total Medicare payments to hospices more than quadrupled from 2000 to 2010 due to increased enrollment and longer lengths of stay.

Chart 11-9. Hospice use increased across beneficiary groups from 2000 to 2010

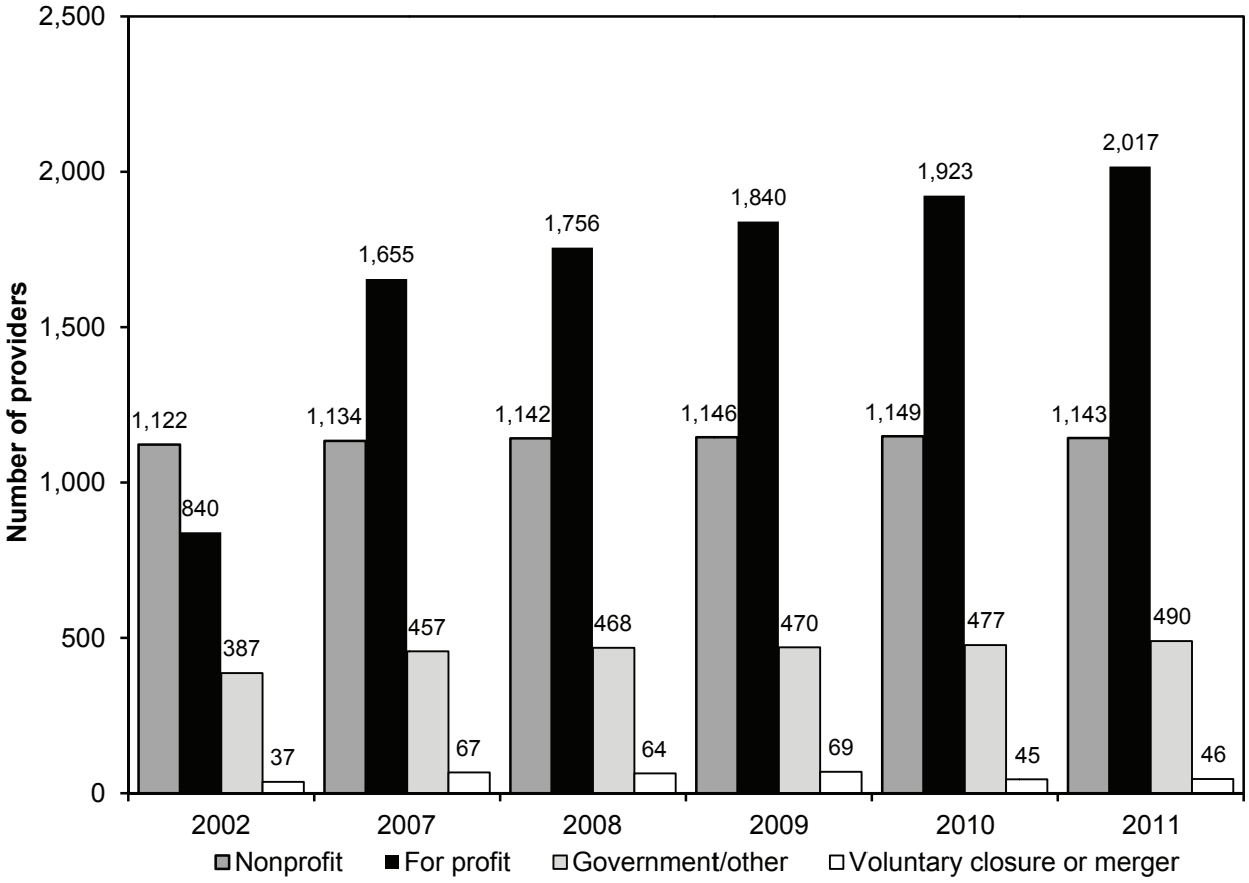
	Percent of decedents using hospice			Average annual percentage point change	Percentage point change
	2000	2009	2010	2000–2009	2009–2010
All	22.9%	42.0%	44.0%	2.1	2.0
FFS beneficiaries	21.5	41.0	43.0	2.2	2.0
MA beneficiaries	30.9	46.1	47.8	1.7	1.7
Dual eligibles	17.5	37.5	39.2	2.2	1.7
Nondual eligibles	24.5	43.4	45.5	2.1	2.1
Age (years)					
<65	17.0	26.0	27.2	1.0	1.2
65–84	24.7	41.0	42.6	1.8	1.6
85+	21.4	48.0	50.4	3.0	2.4
Race/ethnicity					
White	23.8	43.7	45.8	2.2	2.1
Minority	17.3	32.0	33.6	1.6	1.6
Gender					
Male	22.4	38.6	40.4	1.8	1.8
Female	23.3	45.1	47.1	2.4	2.0
Beneficiary location					
Urban	24.3	43.5	45.4	2.1	1.9
Micropolitan	18.5	37.5	39.8	2.1	2.3
Rural, adjacent to urban	17.6	36.9	38.7	2.1	1.8
Rural, nonadjacent to urban	15.8	32.8	34.5	1.9	1.7
Frontier	13.2	27.1	30.1	1.5	3.0

Note: FFS (fee-for-service), MA (Medicare Advantage). Beneficiary location reflects the beneficiary's county of residence. Urban, micropolitan, and rural designations are based on the urban influence codes. The frontier category is defined as population density equal to or less than 6 persons per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

- Hospice use grew in all beneficiary groups in 2010, continuing a decade long trend of increased hospice use rates.
- Despite this growth, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, MA enrollees, not dual eligible, or lived in an urban area were more likely to use hospice than their counterparts.

Chart 11-10. Number of Medicare-participating hospices has increased, largely driven by for-profit hospices



Source: CMS Providing Data Quickly Query. https://pdq.cms.hhs.gov/index.jsp.

- There were more than 3,600 Medicare-participating hospices in 2011. A majority of them were for-profit hospices.
- Between 2002 and 2011, the number of Medicare-participating hospices grew by about 1,300. For-profit hospices accounted for over 90 percent of that growth.
- In 2011, just over 45 hospices voluntarily exited the Medicare program due to a closure or merger, compared with over 60 hospices annually from 2007 to 2009.

Chart 11-11. Hospice cases and length of stay, by diagnosis, 2009

	Diagnosis share of total cases	Percent of cases with length of stay greater than 180 days
Cancer (except lung cancer)	22%	10%
Circulatory, except heart failure	10	19
Debility, NOS	10	25
Lung cancer	9	8
Heart failure	7	21
Unspecific symptoms/signs	6	24
Alzheimer's and similar diseases	6	35
Chronic airway obstruction, NOS	6	26
Dementia	5	30
Organic psychoses	4	29
Respiratory disease	3	11
Genitourinary disease	3	5
Nervous system, except Alzheimer's	3	32
Other	1	11
Digestive disease	1	8
All	100	20

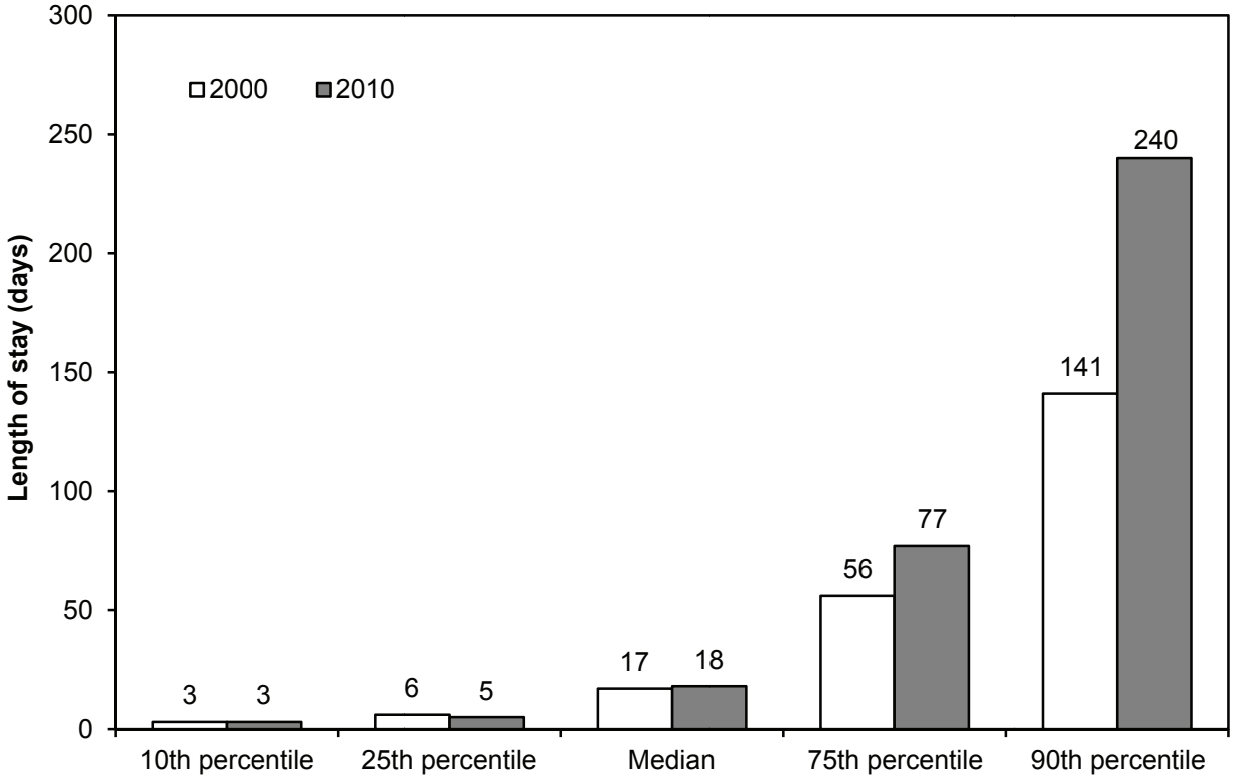
Note: NOS (not otherwise specified). Percent of cases by diagnosis does not sum to 100 due to the exclusion of patients with multiple diagnoses. Share of cases may not sum to figures cited in the text below due to rounding.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytical File from CMS and the Medicare Beneficiary Database.

- In 2009, the most common terminal diagnosis among Medicare hospice patients was cancer, accounting for nearly one-third of cases. The next most common diagnoses were heart failure and other circulatory conditions (18 percent of cases) and Alzheimer's disease, dementia, organic psychoses, and other neurological conditions (17 percent of cases).

- Length of stay varies by diagnosis. At least one-quarter of hospice patients with Alzheimer's disease, dementia, organic psychoses, chronic airway obstruction, and debility had lengths of stay exceeding 180 days. Long hospice stays were least common among beneficiaries with genitourinary disease, digestive disease, and cancer.

Chart 11-12. Long hospice stays are getting longer, while short stays remain virtually unchanged, 2000 and 2010



Note: Data reflect hospice length of stay for Medicare decedents who used hospice at the time of death or before death. Length of stay reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

Source: MedPAC analysis of the denominator file and the Medicare Beneficiary Database from CMS.

- Long hospice stays have grown longer. For example, hospice length of stay at the 90th percentile grew from 141 days in 2000 to 240 days in 2010.
- Short stays in hospice have changed little since 2000. The median length of stay in hospice held steady at 17 or 18 days from 2000 to 2010. Hospice length of stay at the 25th percentile has remained at 5 or 6 days since 2000.

Chart 11-13. Hospice average length of stay among decedents, by beneficiary and hospice characteristics, 2009

	Average length of stay among decedents (in days)
Beneficiary	
Diagnosis	
Cancer	53
Neurological	132
Heart/circulatory	76
Debility	98
COPD	107
Other	85
Site of service	
Home	87
Nursing facility	107
Assisted living facility	143
Hospice facility or hospital	14
Hospice	
For profit	100
Nonprofit	69
Freestanding	87
Home health based	70
Hospital based	62

Note: COPD (chronic obstructive pulmonary disease). Average length of stay is calculated for Medicare beneficiaries who died in 2009 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytical File data, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file data from CMS.

- Hospice average length of stay varies by both beneficiary and provider characteristics.
- Beneficiaries with neurological conditions, COPD, and debility have the longest average length of stay while beneficiaries with cancer have the shortest stays on average.
- Beneficiaries who receive hospice services in assisted living facilities and nursing facilities have a longer average length of stay than beneficiaries who receive care at home or in a hospice facility or hospital.
- For-profit hospices have a longer average length of stay than nonprofit hospices.
- Freestanding hospices have a longer average length of stay than home health–based or hospital-based hospices.

Chart 11-14. Hospice aggregate Medicare margins, 2003–2009

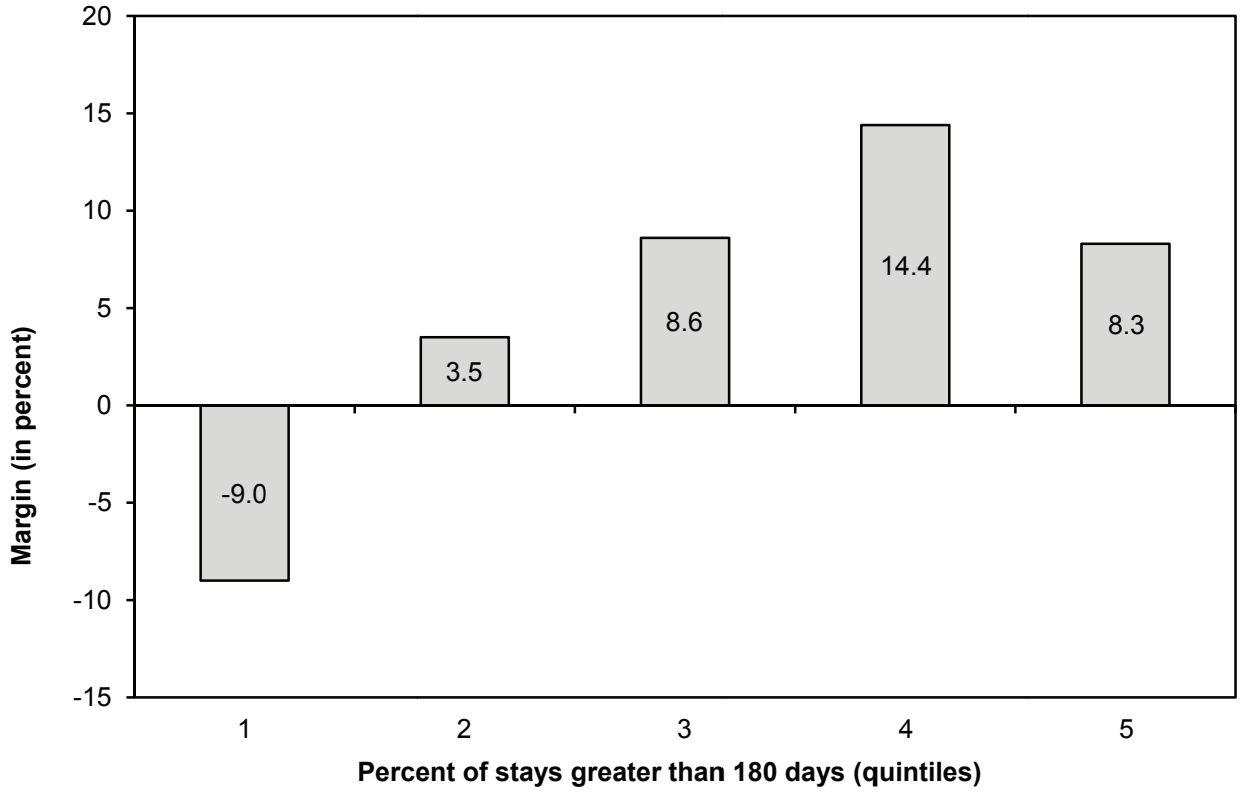
	Percent of hospices (2009)	2003	2006	2007	2008	2009
All	100%	6.6%	6.4%	5.8%	5.1%	7.1%
Freestanding	69	10.9	9.7	8.7	8.0	10.0
Home health based	16	3.9	3.8	2.3	2.7	5.2
Hospital based	15	–14.0	–12.8	–10.7	–12.2	–12.8
For profit	54	15.7	12.0	10.4	10.0	11.4
Nonprofit	33	1.1	1.5	1.7	0.2	3.4
Urban	70	7.4	7.1	6.3	5.6	7.6
Rural	30	0.1	0.8	1.4	1.3	3.1
Below cap	87.5	6.7	7.0	6.1	5.5	7.6
Above cap	12.5	3.5	0.3	2.5	1.0	1.3
Above cap (including cap overpayments)	12.5	23.9	20.7	20.5	19.0	18.3

Note: Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. Percent of hospices does not sum to 100 by freestanding/provider-based categories and ownership categories because skilled nursing facility–based hospices and government hospices are not broken out separately.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims Standard Analytic File, and Medicare Provider of Services data from CMS.

- The aggregate Medicare margin was 7.1 percent in 2009, up from 5.1 percent in 2008.
- Margin estimates do not include nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.5 and 0.3 percentage points, respectively). Margins also do not include the costs and revenues associated with fundraising.
- Freestanding hospices had higher margins than provider-based (home health- and hospital-based) hospices, in part due to differences in their indirect costs. Provider-based hospices' indirect costs are higher than those of freestanding providers and are likely inflated due to the allocation of overhead from the parent provider.
- In 2009, for-profit hospice margins were strongly positive at 11.4 percent. The aggregate margin for nonprofit hospices was 3.4 percent. The subset of nonprofit hospices that were freestanding had a higher margin of 6.2 percent (not shown in table).
- Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a margin of more than 18 percent before the return of the cap overpayments.

Chart 11-15. Medicare margins are higher among hospices with more long stays, 2009



Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims Standard Analytic File from CMS.

- Medicare's per-diem-based payment system for hospice provides an incentive for longer lengths of stay.
- Hospices with more long-stay patients generally have higher margins. Hospices in the lowest length-of-stay quintile have a margin of –9.0 percent compared with a 14.4 percent margin for hospices in the second highest length-of-stay quintile.
- Margins are somewhat lower in the highest length-of-stay quintile (8.3 percent) compared with the second highest quintile (14.4 percent) because some hospices in the highest quintile exceeded Medicare's aggregate payment cap and must repay the overage. Hospices exceeding the cap had a margin of more than 18 percent before the return of overpayments (Chart 11-14).

Chart 11-16. Hospices that exceeded Medicare's annual payment cap, selected years

	2002	2004	2006	2008*	2009*
Percent of hospices exceeding the cap	2.6%	5.8%	9.4%	10.2%	12.5%
Average payments over the cap per hospice exceeding the cap (in thousands)	$470	$749	$731	$571	$485
Payments over the cap as a percent of overall Medicare hospice spending	0.6%	1.7%	2.4%	1.7%	1.7%

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year.
*The estimates for 2008 and 2009 each use a slightly different calculation approach, reflecting changes in the estimation methodology and data availability, and are thus not precisely comparable to earlier years.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File data, Medicare hospice cost reports, Provider of Services file data from CMS, and CMS Providing Data Quickly system. Data on total spending for each fiscal year are from the CMS Office of the Actuary.

- The percent of hospices exceeding Medicare's aggregate average per beneficiary payment limit, or "cap," was 12.5 percent in 2009.
- Medicare payments over the cap represented 1.7 percent of total Medicare hospice spending in 2009.
- Our estimates of hospices exceeding the cap are not entirely comparable over time due to refinements to our estimation methodology in 2008 and 2009. On the basis of additional analyses performed with the revised methodology, we believe the percent of hospices exceeding the cap increased each year from 2002 to 2009, while the percent of total payments over the cap and the average amount of the overpayment per above-cap hospice have declined since 2006.

Chart 11-17. Length-of-stay and live discharge rates for above- and below-cap hospices, 2009

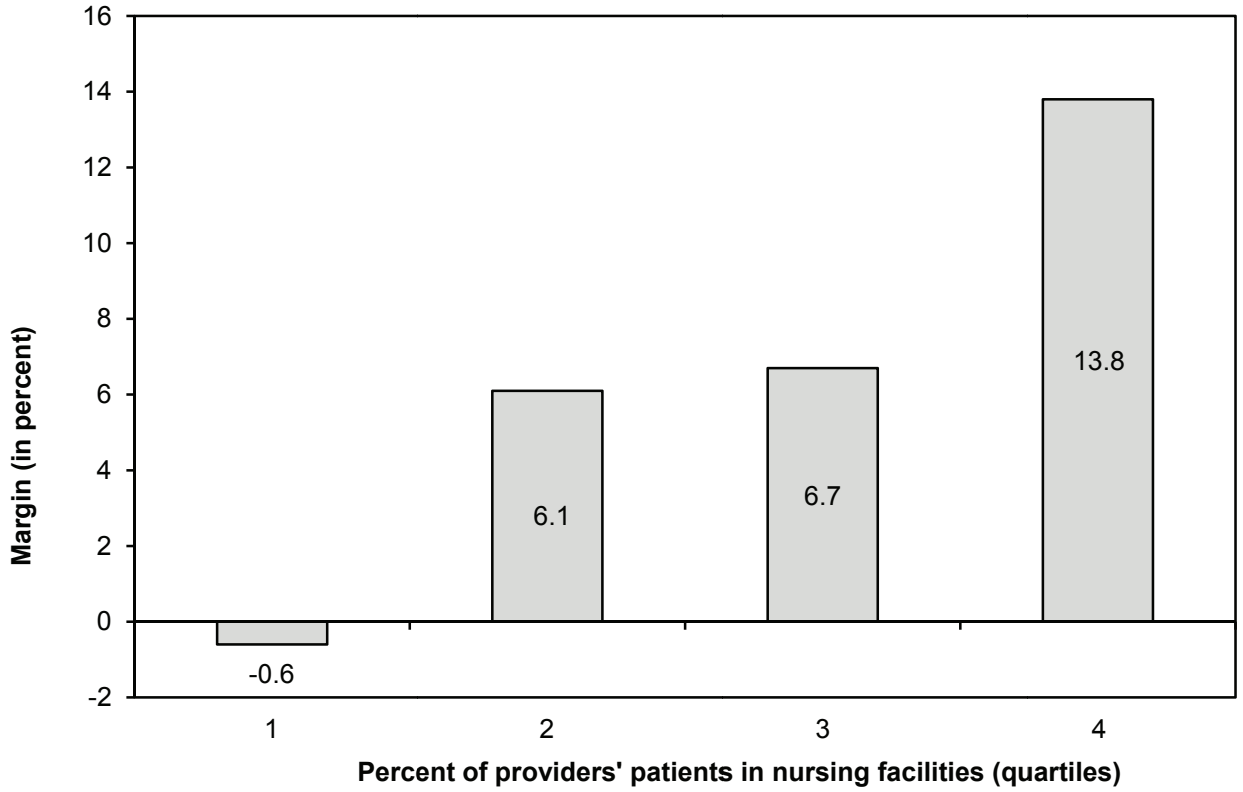
Diagnosis	Percent of hospice users with stays exceeding 180 days		Live discharges as a percent of all discharges	
	Above-cap hospices	Below-cap hospices	Above-cap hospices	Below-cap hospices
All	42%	19%	44%	16%
Cancer	17	9	21	10
Neurological conditions	50	30	35	17
Heart/circulatory	44	18	48	14
Debility	43	23	49	20
COPD	46	25	51	20
Other	49	23	57	25

Note: COPD (chronic obstructive pulmonary disease). Length-of-stay data reflect the percent of hospice users in 2009 whose hospice length of stay was beyond 180 days.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File and denominator file from CMS.

- Above-cap hospices have substantially more patients with very long stays and more live discharges than below-cap hospices for all diagnoses.
- Between 43 percent and 50 percent of above-cap hospices' patients with neurological conditions, heart or circulatory conditions, chronic obstructive pulmonary disease, or debility had stays exceeding 180 days compared with 18 percent to 30 percent at below-cap hospices.
- For all diagnoses, the live discharge rates at above-cap hospices were at least double and, in some cases, more than triple the rates at below-cap hospices. For example, among patients with heart or circulatory conditions, 48 percent of discharges at above-cap hospices were live discharges compared with 14 percent at below-cap hospices.

Chart 11-18. Margins are higher among hospices with a greater share of their patients in nursing facilities, 2009

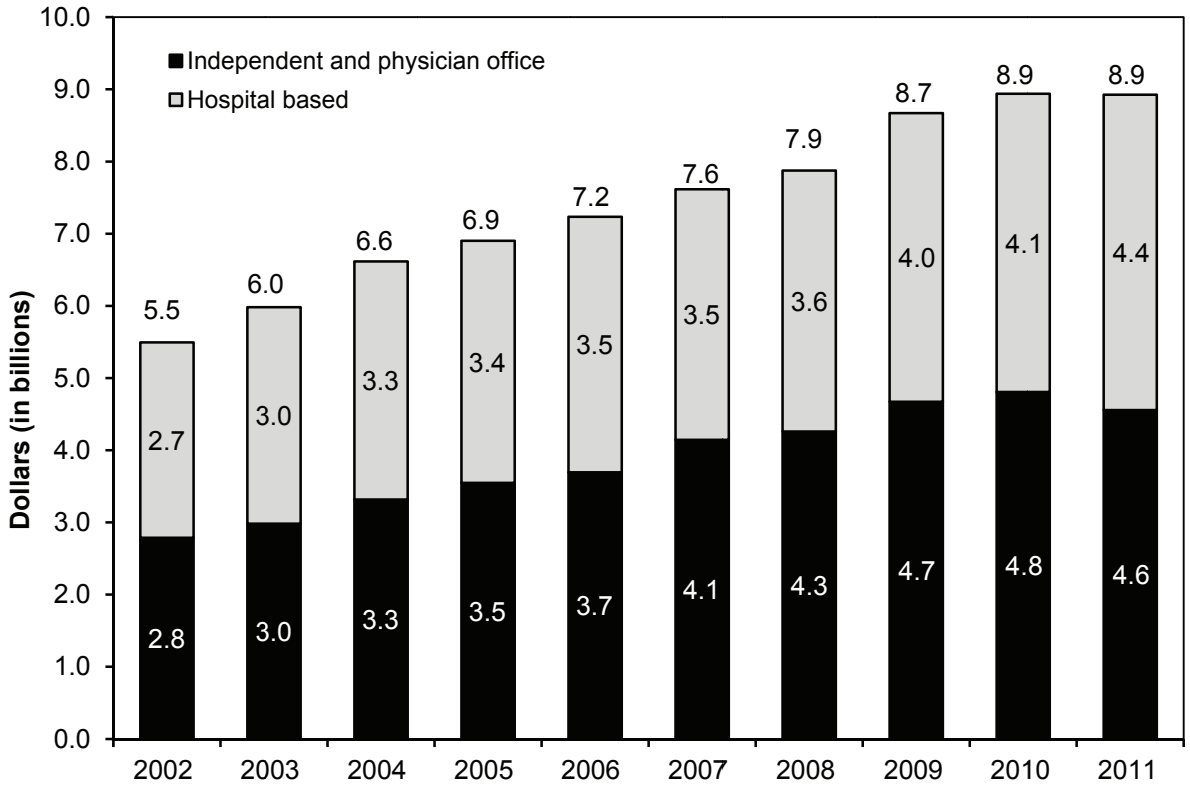


Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims Standard Analytic File from CMS.

- Hospices with a large share of their patients in nursing facilities have higher margins than other hospices.
- The higher profitability of hospices serving many nursing facility patients may be due to a combination of factors, such as longer lengths of stay, efficiencies in treating patients in a centralized location (e.g., less mileage costs and staff time for travel), and savings from an overlap in supplies, equipment, and services provided by the hospice and nursing facility.

Chart 11-19. Medicare spending for clinical laboratory services, 2002–2011



Note: Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services are furnished in labs owned or operated by hospitals. Total spending appears on top of each bar. The segments of each bar may not sum to the totals on top of each bar due to rounding. The spending data are calendar year figures from the 2012 annual report of the Medicare Trustees. In data books from prior years, we presented fiscal year data prepared by the CMS Office of the Actuary for the President's Budget request.

Source: 2012 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending for clinical laboratory services grew by an average of 5.5 percent per year between 2002 and 2011. This growth was primarily driven by rising volume, as there were only two increases in lab payment rates during those years (1.1 percent in 2003 and 4.5 percent in 2009).
- Spending increased by 10.1 percent in 2009 and 3.1 percent in 2010. Spending was flat in 2011 because a 1.75 percent reduction in payment rates offset increased volume. Clinical lab services accounted for 1.6 percent of total program spending in 2011.
- Hospital-based labs' share of total clinical lab spending increased from 46 percent in 2010 to 49 percent in 2011.

Web links. Other services

Dialysis

- More information on Medicare's payment system for outpatient dialysis services can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_dialysis.pdf

- The U.S. Renal Data System provides information about the incidence and prevalence of patients with renal disease, their demographic and clinical characteristics, and their spending patterns.

  http://www.usrds.org

- The National Institute of Diabetes and Digestive and Kidney Diseases provides health information about kidney disease for consumers.

  http://www2.niddk.nih.gov/

- CMS provides specific information about each dialysis facility.

  http://www.medicare.gov/Dialysis/Home.asp

- Chapter 6 of the MedPAC March 2012 Report to the Congress provides information about the financial performance of dialysis facilities.

  http://www.medpac.gov/chapters/Mar12_Ch06.pdf

- MedPAC's June 2005 Report to the Congress recommends changes to how Medicare pays for composite rate services and injectable drugs.

  http://www.medpac.gov/publications%5Ccongressional_reports%5CJune05_ch4.pdf

- MedPAC's October 2003 report describes how Medicare could modernize the outpatient dialysis payment system.

  http://www.medpac.gov/publications/congressional_reports/oct2003_Dialysis.pdf

- MedPAC's comment on revisions to payment policies under the physician fee schedule for calendar year 2004 includes changes in how to pay for services furnished by nephrologists.

  http://www.medpac.gov/documents/100603_RevPhysFeeSched_CB_comment.pdf

- MedPAC commented on CMS's proposed rule to implement provisions of the Medicare Improvements for Patients and Providers Act of 2008 that modernize the outpatient dialysis payment system by broadening the payment bundle in 2011 and implementing a quality incentive program in 2012.

  http://www.medpac.gov/documents/End%20Stage%20Renal%20Disease.pdf

Hospice

- More information on Medicare's payment system for hospice services can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_hospice.pdf

- Additional information and analysis related to the Medicare hospice benefit and the financial performance of hospice providers can be found in Chapter 11 of MedPAC's March 2012 Report to the Congress.

  http://www.medpac.gov/chapters/Mar12_Ch11.pdf

- Additional analyses of Medicare hospice visit patterns can be found in the online appendix to the hospice chapters in the March 2011 and March 2010 Report to the Congress.

  http://www.medpac.gov/chapters/Mar11_Ch11_APPENDIX.pdf

  http://www.medpac.gov/chapters/Mar10_Ch02E_APPENDIX.pdf

- Recommendations for reforms to the hospice payment system and steps to improve accountability and oversight of the benefit can be found in Chapter 6 of MedPAC's June 2009 Report to the Congress.

  http://www.medpac.gov/chapters/Mar09_ch06.pdf

- CMS maintains a variety of information related to the hospice benefit.

  http://www.cms.gov/Center/Provider-Type/Hospice-Center.html

- CMS also provides information on hospice for its beneficiaries.

  http://www.medicare.gov/Publications/Pubs/pdf/02154.pdf

Clinical laboratory

- More information on Medicare's payment system for clinical lab services can be found in MedPAC's Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_clinical_lab.pdf

- Information about CMS's regulation of clinical laboratories, including the number and type of certified labs in the United States, can be found on the CMS website.

  http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html